MCH/CSHCN Director Webcast -- May 2003

>> Good afternoon, everybody, I'm Peter van Dyck.
It's good to have you here this Thursday afternoon.
Chris and I were just talking.
We'll stop saying which broadcast this is because we are beginning to lose track during the months and we're having other broadcasts as well for training and research and other divisions and grant programs.
So we're utilizing the technology more and more.

It's good that you're all here.
Over the last couple of months, the system has switched and the new system is entirely up now so I need to go through the directions just a little bit for some of you who may be joining for the first time.
And seeing it on your screen.
The slides will appear in the central window and should advance automatically.
They'll be in the middle of your screen now.
The slide changes are sin con iced with the speaker's presentations, they advance automatically.
You don't have to do anything to advance the slides.
You may need to adjust the timing a little bit of the slides to match the audio.
Over on the top right there is a slider bar that is probably about 15 seconds right now.
You can slide it to the left to decrease the time and slide it to the right to increase it to synchronize your slides to the audio.
Again, we encourage you at any time during our presentation to ask questions.
Simply type your question in the white message window on the right now of the interface.
There is a little pull-down menu and it says question for speaker as well as a couple of other drop-down items.
Just type in after you select question for speaker and hit the send button.
Be sure to state your organization and it's nice to know what state you're from when you type the question so we know where you're participating.

We'll relay the questions on periodically to our speaker today so that you can have them answered directly.
Again, you can submit those questions at any time during the broadcast.
On the left of the interface is the video window.
You can adjust the volume of the audio with us speaking to you now using the volume control slider which you can access by clicking on the loudspeaker icon.
So click that little icon, you can adjust the volume of our presentation.
Those of you who selected accessibility features when you registered, you'll see text captioning underneath the video window.
So you might want to try that either this time or next time.
So if you have selected accessibility functions, you'll see captioning under the video window.
So I think those are kind of the new items we have for you.
Give them a try.
Be sure to type us a question as the presentation goes on.

Today we have one presentation.
It's important enough that we thought it should take the entire time and that you may have enough questions to fill most of the time.
It's on the new bioterrorism guidance which is in the Maternal and Child Health Bureau, it's in the Division of Child, Adolescent and Family Health.
Rick Smith is the branch chief of the branch where bioterrorism resides and Rick Niska is the Director of the Bioterrorism Hospital Preparedness Program and he's our presenter today.

Rick, we know you've been busy working on a new guidance and I think we would like to hear some of that.

>> Absolutely.
Well, I appreciate the opportunity to talk to this group today.
I actually had a chance to give this as a dry-run presentation to the American College of Emergency Physicians yesterday but it was a live audience so hopefully the interaction will be positive even though I can't see all of you, although I know you can see me.

>> They are still a live audience.
[LAUGHTER]

>> Okay.
Yes.
What I've been asked to do today to explain the National Bioterrorism Hospital Preparedness Program.
It's a year old.
Many of you know during fiscal year 2002 we had approximately $125 million dollars of cooperative agreement money out to the state health departments and health departments of territories, selected cities as well to implement our hospital preparedness for any bioterrorist epidemics.

This year the guidance is very much expanded because the legislation allowed us to expand beyond our first mandate which was biological terrorism.
I'll be getting into what that consists of later on.
It's to ready hospitals and supporting health care systems to deliver coordinated and effective care to victims of terrorism or other public health emergencies.
We wanted to keep it short so you could see what we were about.
Each word means something.

First of all, hospitals is the prime focus of this grant.
But the supporting health care entities help us realize the hospitals are part of a larger health care system.
Emergency medical services, portions of that health care system.
Our grant funds are to fund all these entities in coordinated response in a terrorist -- we're saying terrorism this year not merely bioterrorism.
Most of the terrorist attacks most recently have been other than biological attacks.
Although we spent a lot of time preparing for smallpox and actually have had some experience with real Anthrax and also much more experience with hoaxes that have been, you know, perpetrated but still need a lot of resources to rule out as a credible health threat.
And the last part of that is public health emergencies.

The most recent issue that has come up is SARS.
Can we use our bioterrorism money to prepare for something like SARS?
Our response has been absolutely.
The type of preparations that you would take for a smallpox or a plague, something spread by an air borne route are you what you would do to prepare for something like SARS.
So we see a lot of applicable.
They're similar to a terrorist attack.
We operate with cooperative agreements with all 50 state health departments and the health departments of four cities.
One is the District of Columbia, the nation east three largest Cities, New York, Chicago and Los Angeles county.

In addition the five territories Puerto Rico, Virgin Islands, Guam and others are also existing grantees, we're able to add the Marshall Islands.
Micronesia and PALAU with a total of 62 grantees, it's what the CDC has.

On the next slide we would like to make a point to say this started out as a hospital preparedness program primarily.
Emergency departments are very key to this.
Also inpatient units and critical care areas are particularly important as well as we deal with large numbers of victims of a terrorist attack.
The hospitals are part of a much larger health care system.
Of all the entities you see on the slides.
Poison control centers, EMS were fundable entities during fiscal year 2002.
We're emphasizing it more this year in terms of a health care system response to terrorism.
Poison control centers because they're very good resources.
I used to be a full time practicing emergency physician and it wasn't hard to sell me on the utility of poison control centers because I had made use of these at all hours of the day and night when I had a toxicology emergency to deal with.
In fact the poison control centers were key during the Anthrax epidemic in just giving information to clinicians and also to the general public about what the appropriate treatment and where to deal with Anthrax would be.
They not only deal with poisoning but infectious disease as part of their mission.
We'll encourage them to do that through state funding this year through the state health department.

The other component is emergency medical services.
Important because especially as we move into chemical and explosive types of terrorism to consider, the emergency medical services are much more directly involved in this than they might be say in an epidemic which presents more subtly over time.
Again, an entity during fiscal year 2002 but receives much more emphasis during 2003 and beyond.

The third is the health centers.
Outpatient centers and the community health centers which are funded through HRSA as key partners.
This is basically to make the point that we coordinate our care and make it effective through partnerships with our sister agency the centers for disease control.
Also have a program for terrorism response which is directed at the state and local health departments.
The difference between their program and our program is we deal with the clinical care entities such as hospitals and so forth.
We need to coordinate the response to patients who appear in a clinical setting would be tied in through various mechanism which I will discuss in more detail later on.
Making that interface happen between hospitals and health departments in a more seamless sort of arrangement.

The other agency is the Office of Emergency Response which used to be the Office of Emergency Preparedness within the Department of Health and Human Services.
This office changed it name and was moved over to homeland security but they're the ones who fund the metropolitan medical responses that are key in any sort of terrorism or disaster response.
We ask our states to coordinate with those systems in coming up with a coordinated response.
In the next slide we speak about terrorism and other public health emergencies which I introduced earlier.

There is an expansion of scope this year.
It used to be bioterrorism solely.
This is my own coinage.
Bioterrorism plus.

The legislation asks us to deal with that first as the primary priority and the main focus is on the biological agents.
The legislation also allows us to go into chemical, radiological and explosive threats this year as well.
The readiness for diseases, explosive emergencies that feed into the trauma centers to respond to other types of emergencies as well.
The bioterrorism attack will hopefully never occur but all the funding we're putting into state health departments will ready the nation to deal with other threats that do okay.
The flu presents every year.
The other epidemic that we worry about is SARS, which was kind of a surprise to us.
But it is a major infectious disease player just in the last few weeks which we've had to respond to as well as the CDC.

On the next slide the hospital preparedness program began in 2002 with $135 million appropriated for hospital preparedness.
We were increased to $514 million this year in 2003.
And the guidance was just published through all the appropriate clearances last Friday which gave me a great weekend of not having to worry about it.
We're pleased to have the guidance out in final.
It's available on the HRSA website and click on bioterrorism you can pull up a PDF version of that guidance if you haven't already seen that.

On the next slide I just would like to introduce the five priority areas.
It's not quite that simple because some of those priority areas have several critical benchmarks under them which I'll go into.
But basically the priority areas are five.
We tried to organize them logically this year.
More logically than last year.

The first is search capacity for adults and children.
Speaking to this audience and colleagues every day in the workplace, you know, I have to keep in mind that we -- this is not just an adult response, bioterrorism isn't just for adults.
There were also children involved and one slide I didn't put in here but which occupies a prominent place is the statement of focus that we will be -- the entire grant application process and the development of work plans be continually considered both adults and children as part of the bioterrorism response.
And our response to any type of terrorist emergency.
So that's not only stated up front but it is also stated throughout the grant guidance.
The search capacity area, the longer name for that is search capacity for adult and peed on -- pediatric victims of trauma so we keep making the point that children need to be considered in all of this.
Okay.
Search capacity is one priority area.

Emergency medical services has its own priority area.
Public health departments.
We're talking about labs and surveillance.

Education and preparedness training and also to culminate all of those terrorism preparedness exercises that we can use to test out the system that's been prepared in response to our grant guidance.

I have a few slides on search capacity to tell you a little bit about what that represents to us. And some of the goals that we would like to accomplish through the program.
The most obvious definition of that is hospital bed capacity.
You have the physical space to put large numbers of patients presenting to outpatient systems and the hospital and emergency department that will be taking care of them.
So that's one part of it.
The goal that we had is that grantees should be able to plan for five acutely ill patients with a chemical explosion.
500 patients per million population.
We had the 500 number but the denominator was kind of hard to find in hospital regions.
Of course, everybody could define that any way they wanted.
This year we've decided to use a population denominator so it's 500 per million.

So not only bed capacity but decontamination facilities especially during a chemical attack that we would need to be decontaminating large numbers of people.
To be able to decontaminate 500 patients per million population.
Closely related to that is isolation facilities.
Many grantees have more than one isolation facility within their jurisdiction.
The idea is that there should be at least one isolation unit per grantee fundable under this grant.
These are fairly major isolation facilities.
They should be able to support at least ten patients at a time as opposed to having an isolation facility that is only appropriate for one or two patients at a time.
It's one of the goals to allow states to do that.

On the next slide more components of search capacity.
If you have decontamination facilities and isolation facilities it didn't do you much good unless you have the personnel to deal with the patients.
The department set a goal of 250 additional health care personnel over and above the people that would normally be working in health care facilities.
250 additional health care personnel per million in urban areas and we cut it down by half in the rural areas as a goal.
Tied to that would be personal protective equipment to accommodate at least that number of extra people.
Not in the protective equipment needs to be issued to them all but whether it's those people or the existing people who are taking care of the emergency, that we would have at least that amount of personal protective equipment fundable to protect those personnel.

On the next slide we've also set goals for mental health.
Mental health was kind of talked about in the guidance last year along with a lot of other things but we've got a specific critical benchmark having to do with mental health this year recognizing in all disasters you have medically acutely injured people but a much larger number of people who are affected by, you know, mental health concerns whether it be exposure to a bioterrorist agent that makes people think they're sick or start developing symptoms or may have had family members who were affected by this or killed by the terrorist attack.
A whole host of mental health concerns that we've experienced during the world trade center and all also with the Anthrax epidemic afterwards.
The idea behind our priority area here is to provide both acute and long term care for 5,000 clients per million population.
From acute intervention, post traumatic stress syndrome.

Stress debriefing and getting into clients with ongoing mental illness with the required medication, the issue of not being able to provide medications, antidepressants and anti-sigh cot ix to folks who need them during a disaster.
It's a big priority area.
But we've set the critical benchmark at 5,000 clients per million there.
Trauma and burn care for the first time is under this cooperative agreement.
Based on the input we had from the American College of Surgeons we set the benchmark at slightly what is currently available.
The idea that we would be able to take care through the cooperative agreement 50 severe injuries per million per day in the case of an explosive emergency.

In the next surgical capacity slide we had priority areas for pharmaceutical caches.
The stockpile which is currently in the Department of Health Security contracted back to CDC can be delivered within hours in an ideal setting, hopefully it would occur in a natural disaster setting, too.
I toured the area down in Atlanta and they have a very impressive operation, I have to say.
I believe them when they say they can deliver that.
However, we want to be able to offer states the opportunity to develop their own pharmaceutical caches in an organized fashion so they can give things to health care workers and patients who may be affected by bioterrorist emergency or chemical threat.
Our funding allows local pharmacies to develop stockpile systems to provide clinicians with the appropriate antibiotics and the stockpile is distributed within the jurisdiction that is affected.
The last part of the search capacity is not particularly medical but communications and information technology.
Very critical to just be able to mount an effective response over a large area.

So we -- our goals are that are to essentially have a secure system, a redundant system so we aren't depending on, you know, email or not depending on land mines or cell phones exclusively but have something, communication systems that can be backed up if one part fails.
The other part of communication is connecting the health care system components.
I'll be getting into that with surveillance later on.

Emergency medical services is to develop mutual aid systems in response to terrorism.
This would help, is to get emergency medical systems that are responding to terrorism events but get them involved in an organized fashion involving deployment so that they are doing some good and not, you know, arriving when we don't know what to do with them.
The idea is to get an organized system and credentialing of the EMT's and paramedics that might be crossing state lines to help out an area that has been affected.
Our goal there is the EMS coverage.
We've added the per day denominator to that as well.
Recognizing EMS occurs very rapidly and we need to be able to continually deal with large numbers of people that may be affected.
500 per million per day there.

Next priority area on my next slide is public health departments and two components under that.
One is the laboratory capacity at the hospital level.
CDC already funds laboratory capacity at the state health department level and local health departments but where it stops is going to the hospital level.
It's not that we're trying to make hospital labs into BSA4 facilities with ability to deal with smallpox directly but to establish screening procedures for various types of biochemical agents.
So that at the hospital level they may be doing some screening, possibly early identification of subject pathogens and how to send them off to the appropriate high-level labs at the local or

state or possibly even national health department level for the -- you know, really high-level bacterial agents.
So laboratory capacity at the hospital level a seamless system with the public health department.
Similar to that in terms of the goals is surveillance and patient tracking priority area where we would like to encourage a system of electronic information exchange between clinical settings and health departments so that if a hospital system is seeing large numbers of cases of syndromes that are consistent with a bioterrorist attack that it can be collated and sent on to the health department so we rapidly identify at the clinical level that some sort of syndrome is occurring that needs attention.
So the idea is to bring that down to the hospital and to the EMS and outpatient level in terms of being able to rapidly identify syndromes.

The next priority area on the next slide is education and preparedness training.
There is a multiplicity of training available out there.
We decided to leave the education preparedness in our own grant this year recognizing the CDC has complimentary efforts.
They have the ability to fund training as well and do a very good job at that.
We have a new program within HRSA called the bioterrorism curriculum development program which assesses in the Bureau of Health Professions but they fund curriculum development within medical, nursing schools and other health profession schools but also fund educational programs for practicing clinicians as well.
We didn't want to leave a gap with that with this being a new program this year so we left the ability to fund educational efforts within our grant as well.

The other thing is the grantees differ between their program and ours so we elected to leave that in our program this year again to fill any gaps.
On the next -- our last priority area is the terrorism preparedness exercise.
I view this as is culmination of planning efforts.
You can come up with all sorts of plans, put them on paper, satisfy the feds reviewing the grants but if we don't test this out on the state and local level we don't really know whether we're ready to deal with an epidemic.
With the legislation we've asked our grantees put on at least one terrorism exercise per year during 2003 with a biological terrorism scenario and we also encourage along with that requirement of a biological scenario of other scenarios.
So if they want to use part of their funding to do additional exercises like that, that's certainly encouraged under our program as well.
That basically explains the program.

The last slide I wanted to give some mention to the other programs we've been working with within HRSA.
Actually most of them -- all of them within the injury and EMS branch.
Poison control centers for the regions I mentioned.
Emergency Medical Services for Children because obviously that's a program that we had that specifically focuses on children and has a bioterrorist preparedness component to that, too.
Trauma/EMS.
This is a program that funds collaboration efforts among trauma centers and our own grant program allows additional funds to be given to trauma centers to prepare for explosive emergencies.
Our programs have been working very closely together on that.
The other related programs are Traumatic Brain Injury and violence prevention programs within our branch that all work together in terms of a coordinated response for bioterrorism and other emergency medical services issues.

That concludes the final part of my presentation and if there are any questions I would be glad to try to field those at this time.

>> PETER VAN DYCK: Thank you, Rick.
Really a complete overview of the program.
There are a significant number of changes from last year.
Remember, you can type in your questions on the right-hand side of the screen.
Please type those in and we'll give them to Rick as we're waiting for you to type your questions, let me ask a question.
That is, say a word about the coordination and then HRSA, CDC and the emergency preparedness office downtown, how all this fits together.

>> RICK NISKA: Okay.
Well, for those of you who aren't aware there is an Office of State and Local Programs within the Office of the Secretary -- Assistant Secretary for Public Health Emergency Preparedness.
What that office, which reports to Secretary Thompson, coordinates bioterrorism preparedness efforts within the Department of Health and Human Services.
The two major players on that are HRSA and CDC.
I just explained what we do in HRSA.
CDC, as I mentioned before, has a program very similar to ours which focuses on their traditional constituents.
State and local health departments.
The grantees are the state health departments.
We share the same grantees at the state health department level and I work with hospitals done through contract arrangements or granting type arrangements through that.
These need to be coordinated on the state health department level because they have funding coming from both centers.
The Office of the Assistant Secretary for Public Health Emergency Preparedness has taken the lead in coordinating our efforts and making them a department-wide coordinated response.
The grant applications for both programs will be submitted to both of the individual agencies but then looked over at the same time.
We've developed a good working relationship so even with the departmental coordination CDC and HRSA are working to make sure our programs are well coordinated and it was good to read CDC's guidance and realize they actually get some feedback from the grantees did look a lot more coordinated than it did last year and read the guidance and see that, too.

>> PETER VAN DYCK: Rick, what would you hope the participation of the MCHB in the states would be.
What kind of participation at the state level in this program would you like to see?
What would be ideal in your estimation?

>> RICK NISKA: One thing I didn't mention.
A lot of complexities to this grant.
One area is the idea of a state-wide planning committee.
One critical component of planning committee is having the state maternal and child health advocate as a required member of that committee.
Essentially what we don't want to have happen is that the -- these are children that get lost in all this.
Feeling this is somehow an adult program to the exclusion of other age groups that we feel very strongly about.
One thing that we've done is coordinate quite a bit with the American Academy of Pediatrics and other groups involved with services to children and they've given quite a bit of input in terms of writing the grant guidance of what they would like to see.

So I think in terms of MCH involvement I think I would like to see, my personal preference, I think probably everyone else's, is to have you advocate for inclusion of children and families in the program.
MCH is not the direct grantee, it is the state health department.
To the extent you could participate along with the planning committee keeping an eye on what we're doing and making sure we're responsive.

>> CHRIS DEGRAW: We have a question from Illinois.
Can you explain more about isolation procedures for major catastrophes?

>> RICK NISKA: It really depends on the type of disaster we have.
If we're dealing with smallpox, you know, a rash consistent with smallpox first we have to identify it at such.
A suspect case, and notify the appropriate health departments and, you know, and get a response going that way.
But isolation within the hospital setting would be I think a lot of times when I answer this question I've got to tell people that there is really nothing new under the sun and a lot of what we do is very similar to, say, chicken pox in the health care providers office or dealing with a waiting room with potential infectious diseases.
A lot of emergency departments have protocols where they take suspect rashes, chicken pox that might expose everybody else in the waiting room, move them off to an area where they won't be infecting other people.
The idea of an illness that would be spread by airborne or contact routes or blood-borne routes would be to identify them and get them in an isolation area.

What we're asking in terms of our grantees goals so you can have isolation rooms that we aren't spreading an airborne illness such as a plague, SARS, or flu throughout the hospital settings.
There are interesting studies that have been done that show the spread of infectious agents through a hospital through the ventilation system.
So we're trying to encourage procedures and equipment retrofiting of emergency departments or other appropriate areas in hospitals to prevent that from occurring.
I guess in summary it would be identification of a potential threat and immediately having a system in place where we can get patients off and deal with them in a setting where they aren't infecting a lot of other people.

>> PETER VAN DYCK: We have a number of people in the room here.
Is there anybody here that would like to ask a question?

>> Dr. van Dyck mine is not primarily a question but a comment that is complimentary to this guidance.
That is, is that some of the Congressional long this year directed Secretary Thompson to develop a national advisory committee on children and terrorism.
And they gave a very short window and that was the report had to be completed by June 1.
And this is an advisory committee of multi-disciplines, organizations, federal agencies that have a role.
We sit at that same table.
What I wanted to say, though, is that many of the early recommendations we've had two face-to-face meetings.
There are special reports, special section reports being written, but many of those recommendations that will go to Secretary Thompson have already been incorporated in the work that Rick Niska has done.
There will be one final meeting to write the report.

There are important components of those deliberations that I was afraid might get lost if they were not submitted to the secretary until June 1 and this guidance period would have already passed.
So Rick has incorporated many of those that deal with meds and vaccine protocols and children.
You'll see that in the guidance, too.

>> Good.

>> Most of the children may spend time in school setting.
My question is are we to coordinate with those settings?

>> RICK NISKA: Actually, I've had some discussions with the American Academy of Pediatrics about this.
The idea this whole response isn't just a purely medical one but sometimes there are logistical concerns that need to be dealt with, too.
The concept is what to do when you have -- there has been a decision at the state level, say because of some quarantine reason or because there is a chemical threat and you don't want kids being put into other areas that they might be going into dangerous areas or in I guess just the social chaos that may occur with a terrorist event that people are kind of presenting to schools and yanking their kids out indiscriminately and possibly bringing them into danger.
I guess what AAP has been interested in is trying to just have some sensitivity to protocols and education towards parents as to what sheltering in place might be, when it might be implemented.
Procedures and the reassurance that goes along with that.
I don't know if that addresses your question, but I tried.

>> PETER VAN DYCK: Any other questions from any of you?
Any others from the states?
Okay.
We don't see any.
Rick, thank you very much.
It's been a very comprehensive overview.
We really do hope that the MCH directors will be involved in the emergency committee that the state sets up.
We feel it's a valuable interest that the MCH director should have.
It's not only children, but pregnant women and children with special needs and other special populations as well that you represent.
And you are an important voice for those people.
I know many of you feel you've been shut out of those committees or not invited into them and we're pleading that you perhaps be a little proactive and you might even call Rick and ask him for ways or ideas on how to get into those committees.
You could give them the name of a chair of those committees, a person to call or contact people if you want to know.
So you know exactly who to call to get yourself on one of those committees.
We'll certainly encourage and support that with those committees.

Thank you for being on the broadcast today.
The interface that you're looking at now will close automatically.
And you will have an opportunity to fill out an on-line evaluation.
We would like you to take a minute or two and fill out that evaluation.
Those responses really help us to improve our webcasts to you and as we increase significantly the number of webcasts over this current year, with other divisions and offices within the bureau

and other grant programs utilizing, I think we have two or three just in the next week or ten days.
So those comments by you are really important to us.
Our next broadcast will be a month from now, which is Thursday, June 12.
Look for another broadcast with state MCH directors in matters of interest.
If you have anything you would like to see, go to the website and let us know.
Thank you for joining us today.
Thank you, Rick, for your presentation and we'll see you again next month.
Thank you, good night.